

Don't write in this grey area. For Juno Genetics internal use only	Juno Genetics number	Date received	Received by

**The sections marked with (*) are mandatory to fill in to request the test*

REFERRING CLINIC DETAILS	
Name of referring clinician*	Referring Clinic*
Clinician Email*	

FEMALE PATIENT INFORMATION	
Patient name*	Patient date of birth* DD/MM/YYYY
Patient clinic ID *	Gamete donor* ☐ Yes ☐ No
Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____

CLINICAL INFORMATION				
Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygotity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2 nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygotity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

MALE PATIENT INFORMATION				
Patient name*		Patient date of birth*		DD/MM/YYYY
Patient clinic ID *		Gamete donor*		☐ Yes ☐ No
Sample type*		☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____		
CLINICAL INFORMATION				
Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygotity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2 nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygotity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

DONOR INFORMATION (if applicable)				
Donor ID*		Donor date of birth*		DD/MM/YYYY
Sample type*		Gamete donor*		☐ Egg ☐ Sperm
		☐ Blood ☐ Saliva/ buccal swab ☐ DNA		
CLINICAL INFORMATION				
Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygotity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

REFERENCE INFORMATION

(if applicable; also, in case of additional family members, reuse this page)

1st family member as reference			
Patient name*		Patient date of birth*	DD/MM/YYYY
Gender*	☐ Male ☐ Female	Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____
Relationship to <u>pre-embryos</u> for PGT-M**	☐ Grandparent ☐ Sibling	Affiliation*	☐ Maternal affiliation ☐ Paternal affiliation

CLINICAL INFORMATION				
Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

2nd family member as reference				
Patient name*		Patient date of birth*	DD/MM/YYYY	
Gender*	☐ Male ☐ Female	Sample type*	☐ Blood ☐ Saliva/ buccal swab ☐ DNA ☐ Other _____	
Relationship to <u>pre-embryos</u> for PGT-M**	☐ Grandparent ☐ Sibling	Affiliation*	☐ Maternal affiliation ☐ Paternal affiliation	
CLINICAL INFORMATION				
Genetic disorder*:				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous
2nd Genetic disorder* (if applicable):				OMIM#
Gene*	OMIM#*	Variant*	Inheritance pattern*	Zygosity*
			Choose an item.	☐ Heterozygous ☐ Negative ☐ Hemizygous ☐ Not tested ☐ Homozygous

HEALTH PROFESSIONAL

I certify that, to the best of my knowledge, the patients' and clinical information provided in this form are correct. Based on the clinical indication and my professional expertise, I have requested this test for the patient(s). The limitations of the test, including the fact that PGT-M is not 100% accurate and that prenatal testing is needed to confirm the test result in any pregnancy obtained after PGT, have been explained to the patients and all relevant questions have been answered. I agree to provide any additional information requested by Juno Genetics with regard to this particular test.

Signature of authorised healthcare professional*	Date of request*	DD/MM/YYYY
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